Posttraumatic Stress Disorder: Litigation Strategies

Michael J. Pangia
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MICHAEL J. PANGIA*

I AM CURIOUSLY weak, weak as if I were recovering from a long illness. I begin to feel it more in my head. I sleep well and eat well; but I write a half a dozen words and turn faint and sick.

—Charles Dickens's reaction to the crash of a train in which he was traveling that killed and injured numerous passengers, but left him without physical injury.¹

Mental anguish and illness following a severe trauma is axiomatic in the field of medicine and psychiatry. The legal profession, however, exhibits an understandable reluctance to accept mental pain or illness as a recoverable injury in a tort action. This reluctance stems from the fear that allowing recovery for such injury, notwithstanding the foreseeability on the part of a wrongdoer that such an injury can result from certain malfeasance, will cause a flood of fictitious, speculative claims that would be too difficult to prove or refute. Nevertheless, recoveries for psychological injuries can be significant and, despite the cautious skepticism attendant to such injuries, they present increasing challenges and problems for plaintiffs and defendants in tort litigation.

Among the various mental disorders, Posttraumatic Stress Disorder (PTSD) has emerged as a “designer” mental disorder al-

* Partner in Pangia & Hansen based in Washington, D.C. Certified as a specialist in civil litigation by the National Board of Trial Advocacy. Formerly, assistant chief counsel for litigation, FAA, and Senior Trial Attorney and head of Aviation Trial Unit of U.S. Dept. of Justice.

¹ George Mendelson, *The Concept of Posttraumatic Stress Disorder: A Review*, 10 INT’L J. L. & PSYCHIATRY 45, 48 (1987). It is important to note that some jurisdictions will not allow a recovery for emotional injury without an accompanying physical injury. Others allow recovery for those “in the zone of danger,” and some have expanded beyond that. The applicable law and conflicts of law, beyond the scope of this article, must be determined. This article presumes that this threshold question is answered in the affirmative.
It has been observed that: "[n]o diagnosis in the history of American psychiatry has had a more dramatic and pervasive impact on law and social justice than post-traumatic stress disorder."\(^2\) There are several reasons for this. Undoubtedly, the primary reason is the development of diagnostic criteria for mental disorders generally, lending to the field of mental health care an appearance of objective standards which previously did not exist. PTSD in particular has become such a popular issue in lawsuits in part, because the published criteria for a clinical diagnosis, as set out later, embodies in and of itself the diagnosis of a causal element usually related to a specific traumatic event. Thus, unlike most other mental disorders, the diagnosis of PTSD itself, if accepted, embodies and tends to presume a proximate cause relating to the subject tort. Another reason is an increasing public acceptance of the fact that certain types of trauma do indeed cause significant mental disorders in persons who are otherwise normal. Additionally, the criteria for the diagnosis of PTSD has undergone recent changes, allowing for a broader category of types of causal or triggering events.

Quite often, the plaintiff's lawyer representing a PTSD client does not fully understand the nature and extent of the intrusive force a PTSD victim experiences by the injury. Indeed, often the victim or the victim's family even does not comprehend why the past event continues to so adversely affect them.

"[T]hose who do not feel pain, seldom think that it is felt."\(^4\)

It is particularly challenging to convince a jury of the existence of an injury that cannot readily be seen, or that is seldom experienced by the average person. This article presents some guidelines and personal observations that may be helpful in this regard.

The defense in these cases is confronted with the prospect that PTSD is over-diagnosed, over-treated, and perhaps even ag-

\(^2\) Herbert C. Modlin, Traumatic Neurosis and Other Injuries, 6 Psychiatric Clinics N. Am. 661, 662 (1983), (predicting that PTSD would surface with increasing frequency in catastrophic accident cases). The Modlin article focuses on establishing the validity of PTSD claims.


gravated by the existence of the litigation itself. Of course, the question of malingering arises in these cases either in whole or in part by the exaggeration of symptoms. Are the reported symptoms fabricated for the sake of maximizing a recovery? Many defense lawyers and insurers too often jump to that conclusion and develop personal biases that tend to discredit completely, to their peril, many serious PTSD cases rather than meeting claims with a realistic defense approach. Thus, some of the material and observations presented herein may be helpful to the defense as well.

A conceptual definition of PTSD includes: a complex, varying psychological and biological response to an acute stressor, experienced directly or indirectly, or to chronic stress. It can develop from a tragic event such as a life threatening accident and can have a seriously debilitating effect on the way a person functions with friends, family, occupation and nearly every aspect of one’s life. Although some victims may exaggerate symptoms, PTSD is quite real. In World War I it was called “shell shock.” In World War II, PTSD was recognized as “combat fatigue.” For almost a decade, it was “traumatic neurosis” or “psychic trauma.” It even was known as “railway spine,” because it was thought that the mental or personality change of a railway worker accident victim may have had something to do with compression of the spine. All of these terms have been collected under the present terminology, posttraumatic stress disorder, which appeared for the first time in 1980 in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM, first published in 1952, classifies mental and personality disorders. It is currently in its fourth edition. It is the authority used in psychiatry for diagnoses and provides expanding diagnostic criteria for PTSD, under a broad category of Anxiety Disorders.

Since PTSD first appeared in the DSM, the most significant expansion of its diagnosis is in the type of threshold event neces-

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7 AMERICAN PSYCHIATRIC GLOSSARY (1994).
sary for a PTSD finding. The DSM-III and DSM-III-R\(^9\) required that the triggering event evoke significant symptoms of distress in most people, and generally be "outside the range of usual human experience."\(^{11}\) Examples include events outside of simple bereavement, chronic illness, business losses or marital conflicts. The diagnosis of PTSD under the DSM-III and DSM-III-R began with an identification of the stressor as being an experience such as rape or assault, military combat, flood or earthquake, torture, death camp, or an accidental man-made disaster such as a large fire, sudden collapse of a building, serious automobile accident, or aircraft accident regardless of the presence of physical injury.\(^{12}\)

The DSM-IV deleted the requirement of the event occurring outside the range of normal human experience. It now requires instead that the person "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or that a threat to the physical integrity of self or others"\(^{13}\) and, "the person’s response involved intense fear, helplessness, or horror."\(^{14}\) Additions to the examples of events contained in the diagnostic include natural as well as man-made disasters and being diagnosed with a life-threatening illness.\(^{15}\) Witnessed events may include "observing a serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts."\(^{16}\) Events experienced by others that are learned about may include such things as "violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one’s child has a life-threatening disease."\(^{17}\) The disorder may be especially severe or long lasting when the stressor is of human design rather than one of natural causes.\(^{18}\) The

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\(^9\) See American Psychiatric Ass’n, Diagnostic and Statistical Manual of Mental Disorders (3d ed., 1987) [hereinafter DSM-III].

\(^{10}\) See American Psychiatric Ass’n, Diagnostic and Statistical Manual of Mental Disorders (3d ed., rev., 1987) [hereinafter DSM-III-R].

\(^{11}\) DSM-III, supra note 9, at 236; DSM-III-R, supra note 10, at 247.

\(^{12}\) See DSM-III, supra note 9, at 236; DSM-III-R, supra note 10, at 247.

\(^{13}\) DSM-IV, supra note 8, at 427.

\(^{14}\) Id. at 428.

\(^{15}\) Id. at 424.

\(^{16}\) Id.

\(^{17}\) Id.

\(^{18}\) See id.
intensity may increase as the intensity of the event itself increases or the physical proximity to the event increases.¹⁹

It should be noted that PTSD may occur in persons “who previously had not the slightest psychiatric [or emotional] difficulty” whatsoever.²⁰ However, it is important not to assume that a person who has developed a mental disorder after a disaster is a person who was mentally or emotionally deficient before the disaster.²¹ Likewise, it should never be assumed that the strong person will survive a catastrophic accident emotionally unscathed.²² Those who maintain that emotional problems after tragic events, such as an aircraft crash, are indicators of a pre-existing weakness in the victim, either have never experienced a truly stressful event themselves or have never studied the subject. It should be kept in mind that by definition, the disorder is caused by a stress producing event that is likely to produce psychological trauma in most normal individuals.²³ It has been concluded that the severity of the event itself is the important factor and that, consequently, even individuals with no earlier mental problems could be adversely affected by the level of stress producing this type of injury.²⁴ Therefore, PTSD is not the result of a predisposition, or a so called thin skin. Rather, it is the result of exposure to extreme emotional stress that often occurs in the average human being subjected to events like those listed above. It has been noted that there is little or no evidence that predisposition is a primary factor in predicting the development of PTSD in certain individuals. Although the symptoms and treatment required may relate to an individual’s

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¹⁹ See id. at 424.

²⁰ Martin Blinder, Psychiatry in the Everyday Practice of the Law § 5.2, at 105 (2d ed. 1982).

²¹ It has been observed that the anger which is so often suppressed in the traumatic situation goes underground only to return as a most permanent challenge to the future adjustment of the subject. See Bessel A. van der Kolk, Post-Traumatic Stress Disorder: Psychological and Biological Sequelae 19 (1984).


²³ Those persons who consider a show of distress to be evidence of weakness have been referred to as “hidden victims” of a disaster. See Charles B. Wilkinson, Aftermath of a Disaster: The Collapse of the Hyatt Regency Hotel Skywalks, 140 Am. J. Psychiatry 1134, 1134-39 (1983).

background and past experiences, every normal human being can develop PTSD as a result of a DSM-IV threshold stressor.\textsuperscript{25} While most of the fundamental studies of PTSD developed with the study of soldiers and their responses to combat experiences, attention now focuses on a wider range of experiences such as severe burns, experiences of emergency service staff, traffic accidents, difficult child birth, experiences of critical care nurses, or living in an area with chronic violence.\textsuperscript{26} In fact, some research indicates a startling fact that on the average, about 25\% of the individuals exposed to the DSM-IV defined stressor criteria develop full blown PTSD, and that 40\% of Americans are expected to be exposed to a major traumatic event by the age of thirty.\textsuperscript{27} Therefore, PTSD, when properly diagnosed, is a provable injury that can result from certain tortious conduct and should be considered seriously by both the plaintiff and defense counsel.

The DSM-IV criteria provide that after the experience of a threshold stressor, the victim re-experiences (distinguished from simply remembering) the traumatic event in at least one of the following ways:

1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions;
2. recurrent distressing dreams of the event;
3. acting or feeling as if the traumatic event were recurring, including illusions, hallucinations, and flashbacks;
4. intense psychological stress at exposure to internal or external cues that symbolize or resemble an aspect of the event;

\textsuperscript{25} See John Lipkin, Forensic Assessment of Posttraumatic Stress Disorder in Vietnam Veterans, 1:3 BEHAV. SCI. LAw 419 (1985); see also Bonnie L. Green et. al., Chronic Posttraumatic Stress Disorder and Diagnostic Morbidity in a Disaster Sample, 180 J. NERVOUS MENTAL DISEASE 760, 765 (1992); Robert J. McCaffrey et. al., Civilian-related Posttraumatic Stress Disorder: Assessment-related Issues,45 J. CLINICAL PSYCHOL. 72 (1989).


\textsuperscript{27} See Bonnie Green, Recent Research on Findings of the Diagnosis of Post Traumatic Stress Disorder, Post Traumatic Stress Disorder in Litigation (1995).
(5) physiological reactivity or exposure to internal or external cues that symbolize or resemble an aspect of the event.  

DSM-IV also requires persistent avoidance of the stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by at least three of the following:

(1) efforts to avoid thoughts, feelings or conversations associated with the trauma;
(2) efforts to avoid activities, places and people that arouse recollections;
(3) an inability to recall an important aspect of the trauma;
(4) a remarkably diminished interest or participation in significant activities;
(5) feeling of detachment or estrangement from others;
(6) restricted range of affect (for example, unable to have loving feelings); or
(7) sense of a foreshortened future.  

Further, the subject must experience at least two of the following symptoms that were not present before the trauma:

(1) difficulty falling or staying asleep;
(2) irritability or outbursts of anger;
(3) difficulty concentrating;
(4) hyper vigilance; or
(5) exaggerated startle response.

Clients subjected to severe trauma have reported such things as: “I see it happening over and over again,” “I wake up hearing the screams in my sleep,” “I can’t seem to stop it from happening,” “I don’t know what is happening to me, I never felt this way before,” “I’m a strong person, why can’t I stop this from happening over and over again,” “I am so scared of everything now,” “I cannot even seem to get myself together to even do the little normal things I did before,” “I can’t keep my mind on my work,” and, “I seem to be so scattered and I can’t control it.” Family members and friends often report such observations as: “I can’t understand this change,” “He used to have so much ambition,” “He doesn’t seem to want to even answer the phone anymore,” “This is not him,” “I have known him for years,” “Believe me, what you see on the outside is the same body, but inside there is

28 DSM-IV, supra note 8, at 428.
29 Id.
30 Id.
a totally different person,” and, “Will I ever get my daughter back?”

It is important to note that the DSM-IV provides that the duration of the symptoms must be more than one month, and that “[t]he disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.” Although treatable, PTSD has been known to last for decades and even for life. Thus, in addition to the intangible damages, such as the resulting pain and suffering, and the effects on family, business and social life, other damages, such as the loss of income and the high cost of treatment can result in sizable compensable damages in cases where PTSD is proven in the courtroom.

In the initial interview with a client who has undergone an extreme stressor, the type of which is possibly comprehended by the DSM-IV criteria for PTSD, it is advisable to ask about feelings and experiences along the lines of the symptom criteria set out in the manual, without using the term “PTSD” with the client. An attorney should not attempt a diagnosis. The DSM-IV cautions that “[t]he proper use of these criteria requires specialized clinical training that provides both a body of knowledge and clinical skills.” Of course, if the client is already under care, a study of the medical records and an interview with the care providers are essential. But, if care has not been provided, questioning the client may well provide the basis for advising an evaluation with a skilled psychiatrist and, if appropriate, a prescription from the psychiatrist for a regimen of care and treatment. If PTSD is diagnosed, care and treatment should begin as soon as possible since untreated PTSD seems to become more resistant to treatment over time. The following checklist of symptoms may be helpful in evaluating the existence and extent of an emotional injury such as PTSD:

**Depression**

- Feeling blue
- Feeling no interest in things
- Worrying too much

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31 Id. at 429.
33 See Horowitz, *supra* note 22, at 166.
34 DSM-IV, *supra* note 8, at xix.
35 See Horowitz, *supra* note 22, at 166.
• Feeling hopeless about the future
• Feeling lonely
• Feeling low in energy or slowed down
• Feelings of worthlessness
• Loss of sexual interest or pleasure
• Blaming yourself for things
• Crying easily
• Feeling of being trapped or caught
• Feeling everything is an effort
• Thoughts of ending your life

Anxiety
• Feeling tense or keyed-up
• Heart pounding or racing
• Nervousness or shakiness inside
• Trembling
• Suddenly scared for no reason
• Feeling fearful
• Spells or terror or panic
• Feeling so restless you couldn’t sit still
• Feeling that familiar things are strange or unreal
• Feeling pushed to get things done

Obsessive-Compulsive Behavior
• Trouble concentrating
• Your mind going blank
• Unwanted thoughts, words, or ideas that won’t leave your mind
• Having to check and double-check what you do
• Having to do things very slowly to insure correctness
• Difficulty making decisions
• Feeling blocked in getting things done
• Having to repeat the same actions such as touching, counting, washing
• Trouble remembering things
• Worrying about sloppiness or carelessness

Anger-Hostility
• Feeling easily annoyed or irritated
• Having urges to break or smash things
• Temper outbursts that you could not control
• Shouting or throwing things
• Having urges to beat, injure, or harm someone
• Getting into frequent arguments

**Somatization**

• Headaches
• Numbness or tingling in parts of your body
• Feeling weak in parts of your body
• Heavy feelings in your arms or legs
• Nausea or upset stomach
• Soreness of your muscles
• A lump in your throat
• Hot or cold spells
• Pains in your heart or chest
• Pains in lower back
• Trouble getting your breath
• Faintness or dizziness

Although a lawyer should not attempt an evaluation and determination from a psychiatric standpoint, an attorney handling a posttraumatic stress disorder case should be knowledgeable of the elements of the psychiatric examination. A psychiatric diagnosis of persons without organic pathologies basically consists of three steps: (1) gathering a personal history directly from the patient, (2) a mental status examination whereby subjective observations are made of the subject's appearance and manner of presentation, and (3) psychological testing to standardized clinical impressions.36 The attorney may also learn first-hand of the personal history of the client even before a visit to the psychiatrist. For example, the attorney may be able to have the client describe the way he or she is affected in daily activities as a beginning of the preparation of the damage case. However, as stated, the attorney should seek professional assistance before making any final determination with regard to the existence of a real injury.

In this regard, an attorney can make sure the client does what is necessary to get better. As an example, in a negligent security case,37 an assailant came through a long neglected hole in a fence surrounding an apartment dwelling in the District of Columbia. He made his way to an unlocked basement door, to the

37 Unpublished case on file with author.
elevator, and then forced his way into a young girl's apartment, making her perform sexual acts at knife point. During her interview with me, she reluctantly admitted she was experiencing frightening dreams, recurring intrusive thoughts, sexual dysfunction and feelings of helplessness. She was ashamed of these symptoms, feeling that she was to blame for a weakness in her personality. She never thought of seeking professional help and would never have mentioned these post-event problems were it not for the attorney-client interview. She was comforted by the fact that these feelings were not abnormal. I referred her to a psychiatrist who, after two separate evaluations, concluded that she had developed PTSD, but with a very good prognosis for early recovery. She began a course of treatment that ameliorated most of the symptoms well before the trial of her case.

Handling a case involving posttraumatic stress disorder can in itself be stressful. Before deciding to take on one of these cases with all of the attending difficulties of proof, an attorney should prepare to deal with clients experiencing true emotional problems, the manifestations of which can make the attorney-client relationship very difficult. It is not uncommon for the true PTSD client to turn on the attorney in the course of the litigation. In fact, if a client is quite reasonable, calm, understanding in spirit, and easy to deal with, the attorney should be suspicious of a lack of existence of an emotional problem. Vacillation, confusion, and crying spells, interlaced by periods of unusual self-composure, are common manifestations of a posttraumatic stress disorder victim. Additionally, in the responsible type of individual, the trauma may be enhanced by feelings of survivor guilt. The survivor may attribute much of the damage done in the catastrophic event to some small idiosyncratic decision on his or her part. In that event, it is observed that the guilt is a way of turning a passive experience of overwhelming helplessness into an active experience of excessive responsibility manifested by the self question: “Why did I survive when others did not?”

Often victims feel that their suffering has some conjured mission which cannot be fulfilled by a monetary recovery unless that recovery will somehow stop people from committing the same negligence which they feel invaded their lives.

On the subject of settlement, PTSD victims often find it difficult to rationalize the concept that their experience could possibly be the subject of negotiation or an equation with a monetary

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38 Lindy, supra note 36, at 160.
equivalent regardless of the amount. Therefore, in the genuine posttraumatic stress disorder case, managing a settlement with a client can be difficult because of these emotional problems. Unless there is a full understanding of the symptoms of posttraumatic stress disorder and a psychological preparation to deal with them in the client, tackling this type of case can be a stress-producing event for the plaintiff's attorney. The attorney should be emotionally prepared (and able) to exhibit exceptional patience at times while handling a serious PTSD case.

Sometimes the care for the client's mental well-being as well as the duty to provide the best legal representation, present a conflict. For example, a victim of an airplane crash sustained very minor physical injuries, but through the attorney-client interview, he manifested an unusual denial of the event itself. He admitted to uncontrolled fits of temper and plaguing nightmares, yet he said "I control everything in my life. This crash does not fit, and neither do my problems. Therefore, you see, the crash cannot have any effect on me whatsoever." Despite his attitude, he agreed to a psychiatric evaluation because of his interest in pursuing a personal injury action. The psychiatrist described him as a "ticking time bomb," who needed treatment, and that the stress of the litigation would be harmful in his particular case. In consultation with the client and the psychiatrist, it was agreed that he not pursue the case.\textsuperscript{59} Litigation is often necessary to obtain adequate means for care and treatment for disorders resulting from a tort. In this case, however, litigation would be counterproductive from a mental health standpoint.

The attorney evaluating a case may be confronted with situations where (1) treatment was not timely sought by the client, (2) where a diagnosis of PTSD is missed by a physician, or (3) where treatment is prematurely shortened by health care insurers. Regarding treatment that may appear to be untimely sought, it should be noted that the DSM-IV labels PTSD as "acute" if the duration of the symptoms is less than three months and "chronic" if the duration of the symptoms is three months or more (this is reduced from six months which appeared in the predecessor manuals). PTSD, with delayed onset, is a proper diagnosis if the symptoms begin to occur at least six months after the stressor. It is not unusual for the stressful episode to be followed by an incubation period from eight to sev-

\textsuperscript{59} Client interview during the course of an unpublished case (on file with author).
enty-two hours during which the victim appears calm and psychologically unaffected by the traumatic event. The victim may, in fact, perform in a competent and sometimes heroic manner, seeing to the needs and even saving the lives of others. Then, when the precipitating stress is well passed, a deterioration of the person’s psychological well-being begins to take place. For example, it has been observed that the victims of catastrophic events, particularly those which are “human-induced,” generally pass through stages of initial shock and disbelief, frozen fright, to anger or depression shortly after the event. The disorder then evolves into a wide variety of anxieties and emotional disabilities ranging from detachment or estrangement from other people to loss of ability to enjoy activities to the inability to feel emotions of any type. In well-controlled and disciplined persons, the onset of symptoms has been found to remain latent even for several years after the stressful event. However, it has been observed that prior attitudes, conflicts, personality styles, cultural backgrounds, and networks of social support are invariably combined with responses keyed to the traumatic event. This makes it difficult to diagnosis what degree of the reaction can be attributed solely to the event itself.

Additionally, the syndrome may be well masked by various degrees of denial by the victim. It has been observed that the common symptom, involuntary repetition of the catastrophe in the victim’s mind, stands in contrast to the ostensible opposite symptoms, a massive ideational denial of the event and a general emotional numbness. As an example, the symptoms of denial

40 See DSM-IV, supra note 8, at 425 (specifying PTSD with delayed onset).
41 Lindy, supra note 36, at 160.
43 See Andreasen, supra note 24, at 921 (describing a Vietnam veteran with the onset of symptoms years after his Vietnam experience).
45 It has been observed that the classification of problems resulting from serious life events has oscillated between posttraumatic stress disorder diagnosis and other classes of stress response syndromes which has served in the past to complicate the issue which the DSM intended to resolve. See Mardi Horowitz et al., Signs and Symptoms of Posttraumatic Stress Disorder, 37:1 ARCHIVES OF GEN. PSYCHIATRY 85, 85. Dr. Horowitz maintains that the “cardinal signs of intrusive experience and
and emotional numbness are demonstrated by another recent personal experience. In consultation with a survivor of a recent air crash disaster, the prospective client expressed extreme anger and hostility shortly after the accident but admittedly did not know why or against whom it was directed: “I feel like I could kill someone, but I don’t know who - maybe I’ll kill myself - I’m so mad.” Within several months after the accident, this person began to state how he now had his life back in control, that “the accident did not happen.” “I have always planned my life,” he declared, “and this thing has no place in it. I remember nothing. So you see, this crash did not happen.” Without any provocation, he would describe at length his well-being, interspersed with versions of the same recantation of denial.46

The DSM-IV also provides for differential diagnoses. If the stressor is not of an extreme nature or the symptomatology as set forth in the criteria is not met in one or more aspects, the clinician is directed to consider adjustment disorder, brief psychotic disorder, major depressive disorder, and other disorders that are not always as event-specific as PTSD. For example, symptoms of avoidance, numbing, and increased arousal that are not present before the suspected extreme event, do not meet the criteria of the PTSD diagnosis, and although potentially aggravated by, may not be considered the cause of a mental disorder generally.47 Nevertheless, Acute Stress Disorder is also an event-related condition and a potentially recoverable damage. Other differential diagnoses, less event-specific than PTSD or Acute Stress Disorder, present additional challenges to the proof of causation.

Regarding the problem of prematurely shortened care and treatment, it can be most frustrating, and potentially detrimental, when insurance plans mandate problem-focused, short-term treatment. Of course, there are incidents of abuses of long-term therapy with seemingly no goal in sight, but the pendulum may have swung the other way with HMOs and other medical plans. Now, we are seeing individuals prematurely discharged from needed therapy because the health care coverage mandates short-term treatment and the visits are often “used up,” denying

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47 See DSM-IV, supra note 8, at 427.
Therefore, a shortened or terminated regimen of treatment may not be an indicator of the severity of a particular case of PTSD.

When is PTSD ever cured? The litigation of a PTSD case would quite naturally concern the length of time of required treatment. Is a cure ever effected? While time usually ameliorates most symptoms of PTSD, a cure may never completely occur. Faced with such evidence in the presentation of a PTSD case, consideration should be given to approaching a “cure” in relative terms. How long will psychotherapy be required and what will it accomplish? Marital therapy may not restore a happy marriage, but it may effect a divorce that allows the children to be raised in a conflict-free environment and free the spouses to go on with their lives. Their lives would be normal, but different. Should a “cure” for PTSD be approached with the same rationale? In the discovery process, it is important for the defense to learn what goals are sought by continued psychotherapy, how the goals are to be attained, and how achievement is to be measured. If the goals are not being attained within reasonable time projections, the therapist should be questioned on what alternatives would be considered. Our lives are changing all the time, and even the most healthy among us cannot return to the identical physical or mental condition that existed at a given moment in the past. Likewise, all of us have certain normal levels of stress in our social and occupational functioning. The defense should seek to establish that a cure cannot be defined as a return to stress-free functioning. Whether a return to a reasonable ability to cope with ever-changing social and occupational situations, in this relative context, would be considered a cure, is a question that should be explored in the discovery process.

It is also important to be aware that some advances have been made in the pharmacotherapeutic approach for some of the symptoms of PTSD, although there is no definitive pharmaceutical treatment for PTSD itself. Because there is some overlap in the symptomatology of PTSD with that of major depression and panic disorders, drugs like tricyclic antidepressants have been found useful in suppressing intrusive recollections and hyperarousal, increased startle response, irritability, and rage. But,

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avoidant symptoms such as alienation, detachment and psychic numbing rarely respond to medication. Drug therapy alone is never sufficient to alleviate the suffering in PTSD, however, and it appears to be useful only as an adjunct to psychotherapy for this unique disorder. Nevertheless, it may provide some relief by enabling the patient to participate more thoroughly in individual, behavioral, or group psychotherapy. As a final note, one should be aware of the side effects and contraindications of some of these drugs.

What about the faker? In a diagnosis of PTSD, the attorney as well as the psychiatrist must be able to differentiate the symptoms of posttraumatic stress from those of “compensation neurosis,” a fictitious illness complicated by unresolved monetary claims, and “malingering,” a deliberate simulation or exaggeration of an illness in order to avoid an unpleasant situation or to obtain some type of personal gain. Both of these terms appear in one way or another in almost all litigation involving posttraumatic stress disorder.

Compensation neurosis is regarded as an unconscious psychological factor that may contribute to an illness. There is no question that it may exacerbate posttraumatic stress symptoms. To a trained specialist, however, the symptoms of the faker are sufficiently different from posttraumatic stress disorder symptoms, revealing themselves as a non-causative factor of the symptoms of posttraumatic stress disorder. While the incidence of malingered psychiatric symptoms after an injury is unknown, “pure malingering,” the feigning of an injury that does not exist, is thought to be uncommon in PTSD cases. The differential diagnosis between PTSD and compensation neurosis turns on the extent to which the neurosis has been created by a subjective conviction on the part of the victim that compensation is appro-

51 American Psychiatric Glossary, supra note 7, at 44.
52 Id. at 121.
53 The term “compensation neurosis” was used in the former DSM versions. See DSM-III, supra note 9, at 303. In the DSM-IV, “compensation neurosis” has been deleted, but the subject is embodied in the Differential Diagnosis sections of PTSD and other Anxiety Disorders. See DSM-IV, supra note 8, at 427.
appropriate. An experienced psychiatrist can diagnose symptoms as being outside volitional control and determine if they will persist in the victim whether compensation is awarded or denied.\textsuperscript{56}

Malingering, on the other hand, is deliberate. One author classifies malingering as "a manifestation of crass, deliberate dishonesty - pure and simple."\textsuperscript{57} While there are occasions when a fundamentally honest man finally succumbs to temptation and commits a dishonest act, the degree of dishonesty necessary for successful malingering is usually well-ingrained over a lifelong period.\textsuperscript{58}

\textit{Though this be madness, yet there is method in't.}
- Hamlet\textsuperscript{59}

The DSM-IV classifies malingering as an additional condition that may be a focus of clinical attention and specifies that:

The essential feature of malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. Malingering should be strongly suspected if any combination of the following is noted:

(1) Medicolegal context of presentation (e.g. the person is referred by an attorney),
(2) Marked discrepancy between the person’s claimed stress or disability and the objective findings,
(3) Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen,
(4) The presence of an [additional disorder such as the behavior of professional thieves, racketeers, or dealers of illegal substance].\textsuperscript{60}

It is this author’s observation that the mere mention of the word malingering can be devastating to a plaintiff’s case. Practically speaking, the mere allegation of malingering requires the accused party to disprove the claim of deception.\textsuperscript{61} The most obvious cause for suspicion of malingering is the sufferer’s over-riding preoccupation with a financial recovery rather than a

\textsuperscript{56} See Andreasen, 	extit{supra} note 24, at 923.
\textsuperscript{57} Blinder, 	extit{supra} note 20 at 187.
\textsuperscript{58} Id.
\textsuperscript{59} WILLIAM SHAKESPEARE, \textit{Hamlet} act 2, sc. 2.
\textsuperscript{60} DSM-IV, \textit{supra} note 8, at 683 (emphasis added).
cure. The malingerer shuns treatment, especially if it is inconvenient. They are often deferential to psychiatrists and their lawyers, whereas the true sufferer of the disorder showing apathy or hostility will do so indiscriminately, even towards those who are helping him. The malingerer’s complaints often come and go or are vague in nature. The malingerer may also have a history of dependency and poor impulse control in contrast to the self-reliant, accomplished type.\(^6\)

The DSM-IV prescribes that malingering should be ruled out whenever financial remuneration, benefit eligibility, and forensic assessment play a role.\(^6\) The evaluating psychiatrist or psychologist should be able to make a fairly good assessment of whether the subject victim is malingering from a consideration of the following:\(^6\)

- Review of the progress notes of the person’s therapists or other care givers to observe any significant contradictions;
- Interviews of family members and close friends about reported bad dreams, patterns of sleep, changes in sexual interest, body movements during dreams,\(^6\) and capacity to work;
- Whether the claimant is familiar with the term PTSD and knowledgeable of its symptoms;
- Whether the claimant is evasive during the interview and unwilling to make definite statements about returning to work;
- Whether the person over-acts the symptoms (because malingerers are actors);
- Whether the person has a spotty employment record or extensive absences from work;
- Whether the person depicts his or her pre-accident functioning in exclusively complimentary terms;
- What the person’s asserted capacity is with respect to work as compared to recreation; The true PTSD victim withdraws from recreational activities as well as work.

\(^6\) See Blinder, supra note 20, at 186-87.

\(^6\) DSM-IV, supra note 8, at 427.

\(^6\) See Resnick, supra note 55, at 120-25.

\(^6\) It was observed that posttraumatic nightmares are almost accompanied by considerable body movement. See Bessel A. van der Kolk et al., Nightmares and Trauma: A Comparison of Nightmares After Combat With Lifelong Nightmares in Veterans, 141 AM. J. PSYCHIATRY 187, 189 (1984).
• Whether the person is unwilling to volunteer information about sexual dysfunction but eager to emphasize physical complaints;
• How the claimant reports bad dreams. Malingers who do not know the PTSD symptomatology may reply "I don't know" when asked about nightmares. They may report dreams of the exact occurrence, while the true PTSD victim's dreams generally vary;
• How the person follows advice and reacts to the idea of appropriate drug therapy or other therapeutic advice.

There are some tests which can more objectively detect malingering with a fair amount of reliability. The Minnesota Multiphasic Personality Inventory (MMPI) is a widely accepted objective test of personality used to distinguish between adjusted people and people suffering from emotional or mental disability. The Rorschach is a widely used projective technique for assessing personality. Both have been used as valid indicators of the presence or absence of malingering. The plaintiff's psychiatrist should be able to explain in detail the wide acceptance of the clues and tests used, stressing the presence of the unique DSM-IV symptoms and their debilitating effect. The malingerer simply does not consistently exhibit the symptoms provided in the diagnostic criteria for PTSD. The skilled psychiatrist or psychologist (and often the attorney experienced in dealing with PTSD victims) should be able to readily detect it.

Obviously, the selection of an experienced evaluating psychiatrist or psychologist is crucial to any PTSD case. The considerations that are embodied in this selection are many. Should a psychiatrist or psychologist be chosen as an expert? The psychologist, properly credentialed and experienced in treating PTSD, may well be accepted by the court and sometimes prove to be better communicators than psychiatrists. A common complaint about psychiatrists is that they tend to over-use technical terms. Their fees are higher than those of psychologists and are therefore targets of cross-examination that attempts to show them as manipulating diagnoses for continuing economic gain. So, the decision depends upon the individual's ability to articulate the nature and extent of the injury in layman terms

66 See Adelman & Howard, supra note 61, at 17-18.
67 See Jenkins v. United States, 307 F.2d 637, 643-44 (D.C. Cir 1962) (en banc); see also People v. Davis, 402 P.2d 142, 147-48 (Cal. 1965) (providing that psychologists may testify as experts upon matters within the scope of their competence).
with, of course, sufficient scientific support. I find it effective to combine the psychiatrist's expert testimony with that of a treating psychologist.

In any event, the selection of the expert should not be made without regard to the holding of the Supreme Court in the Daubert case, its prodigy, and the varying state law criteria on acceptance of expert testimony. In the federal courts, the former standard allowed the admission of expert testimony if it were of the type "generally accepted" in the field. Essentially, the Daubert court requires that the expert's testimony have a "grounding in the methods and procedures of science" and knowledge to connote a body of facts or ideas, accepted as truths "on good grounds." It must have "a reliable basis in the knowledge and experience of his discipline" and be relevant, providing a valid connection between the information proffered and the issues involved. Under Daubert, the court is placed more heavily in the role of a "gatekeeper" for expert testimony. Daubert, however, provides few objective guidelines in this process. It seems that the court must make some very subjective determinations regarding expert testimony. In the case of mental health care, it seems that the court is asked to apply a "soft science" in determining the acceptability of another "soft science."

In view of the varying decisions following Daubert and the variety of state court standards, the most effective gatekeeping will be that which is self-imposed by the expert him or herself. One author developed a comprehensive set of guidelines, modified herein, that may be helpful in this field of expertise:

1. Whether the witness is qualified to express an expert opinion.
   - Proper credentials?
   - Did the witness directly examine the plaintiff?
   - Has the psychiatric evaluation been comprehensive with an identification of the complete database upon which the diagnosis proffered?

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69 Daubert, 509 U.S. at 585-86 (citing Frye v. United States, 293 F. 1013, 1014 (D.C. Cir. 1923)).
70 Id. at 590.
71 Id. at 592.
72 See id. at 597.
(2) Whether the facts upon which the expert relies are the same type as relied upon by other experts in the field.
   • Has clinical examination of the plaintiff established a formal psychiatric diagnosis - e.g. conformity to DSM-IV diagnostic criteria?
   • Has the expert clearly explained the theoretical basis for the diagnosis and opinion to be rendered?
   • Will the expert be able to identify, explain, and apply the major diagnostic studies available to substantiate the diagnosis and opinion?
   • Has there been any substantial reliance on novel procedures which have not been generally accepted as valid and reliable?

(3) Whether the expert’s conclusion is based upon well-founded methodology.
   • Is there an established theory of causality?
   • Is there a credible and understandable link among the psychiatric symptoms, etiologic basis for these symptoms, and the legal issue to be considered?
   • To what extent does the opinion derive from generalizations drawn from appropriate behavioral science data in contrast to specific observable data generated in the clinical evaluation?

(4) Whether the probative value of the testimony outweighs potentially unfair prejudice.
   • Will the opinion be relevant to the legal issue, or is its purpose primarily to bolster the plaintiff’s credibility on collateral issues?  

Therefore, licensure as a physician who practices psychiatry or psychology (even board certification in those subjects) may not result in qualification as an expert on the subject of PTSD. The expert’s experience with PTSD must include a thorough study of the vast number of studies, papers, and analyses made on the subject, particularly those made within the last decade leading up to and including the clinical application of the DSM-IV. The expert who is well versed not only to testify but also to

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make the original PTSD diagnosis, must be familiar with and apply new developments in the observations of this disorder. The expert must then be able to communicate to a jury the significance of the studies and how they are considered in the diagnosis of this disorder if an effective case is to be made.\textsuperscript{75}

Should an attorney use the treating physician as an expert? Often the treating psychiatrist or psychologist can be made to appear more credible to a jury than the “paid expert.” This author has successfully used the following line of cross-examination of the defense expert to make that point:

Q: Doctor, you are not the treating physician in this case are you?
A: No.

Q: You have no responsibility whatsoever for the continuing care and treatment of [plaintiff]?
A: That is true.

Q: You were hired only to see the [plaintiff] once or twice only for the purpose of this lawsuit?
A: Yes.

Q: And they are paying you to serve in that fashion, are they not?
A: Yes.

Q: With regard to your own patients for whom you are responsible as a doctor, have you had occasions where, through continuing care and treatment, you have altered or supplemented your diagnosis, both positively and negatively, as time went on?
A: Yes, that happens.

Q: Of course, through no fault of your own, you were never given that opportunity to do that with regard to [plaintiff]?
A: No.

Q: So, at least in that respect, would it be fair to say that, again through no fault of your own, [plaintiff’s treating physician] is perhaps in a better position in that regard to come to a final prognosis or evaluation?
A: Well, maybe.

Realistically, the treating physician may not always prove to be the better expert. In fact, it is often a bad idea in mental disor-

\textsuperscript{75} In research, this author has discovered well over one-hundred books, papers and studies on the subject of PTSD published since 1987, many available in the American Psychiatric Association and National Library of Medicine libraries, located in Washington, D.C.
der damage issues to have the treating physician to act as the expert for the following reasons. Independent evaluators are in a better position to apply their skills impartially. When the treating doctor attempts to give a forensic evaluation, the doctor is affected by a professional and personal bias to the patient. One such conflicting activity is providing therapy, particularly psychiatric therapy, to the plaintiff. Therefore, the roles of the patient ally and the impartial evaluator are too often inconsistent.76

When the treating physician serves as an expert, skilled defense counsel may attempt to elicit an admission that when treating a patient, the treating physician’s interest lies primarily in the perception of the patient’s difficulties, not necessarily in objective reality. In fact, the DSM-IV encourages clinicians to make diagnoses based on self-reports, regardless of their accuracy, in order to treat the patient effectively. The treating physician must develop an atmosphere of trust with the patient, which is not often accomplished by an objective fact-finding approach. It is advisable, therefore, not to place the caregiver in a role that conflicts with the doctor-patient relationship. It could prove to be a detrimental to both the patient’s treatment and the presentation of the case to the jury. The forensic expert, on the other hand, is usually free of these doctor-patient encumbrances. The non-treating expert can review a variety of records and can speak to a number of people who know the litigant. This expert is less likely to be distracted from considering exaggeration or malingering because of the absence of treatment bias. Also, he is not placed in the position of being viewed as having a financial interest in recommending continuing treatment.

The experienced clinician hired to evaluate a case should carefully check the client’s medical and social background. It is advisable for the plaintiff’s attorney to obtain this information first at the very outset of the case—preferably before filing the complaint wherever applicable statutes of limitations permit. One can rest assured that a prepared defense attorney will request the following:

- school records that may contain psychosocial information
- records of previous employment
- names of former spouses together with records of any divorce or child custody proceedings
- private health insurance records
- all records from plaintiff’s pharmacies

76 See Shuman, supra note 74, at 7.
• any criminal history
• any history of alcohol or drug use
• any psychosocial or environmental stressors
• any present or past physical condition that could cause the current symptomatology
• any involvement in unrelated suits or disputes.

It is important to gather this information, study it carefully, and present it to the evaluating psychiatrist or psychologist so that any of the negative aspects can be dealt with up-front. The experienced psychiatrist or psychologist need not be reminded of the questions to ask along the lines of the diagnostic criteria, including those required for differential diagnoses.

On the other hand, it is important to prepare the client properly for an evaluation by the defense psychiatrist or psychologist. Too often the uncanny defendant’s physician may simply ask a question like: “And what do you say the problems are that you are now having?” The evaluator may avoid going through a criteria checklist, expecting that the client should remember all of the varying problems experienced, some of which may be even delayed, masked, or intermittent. Often by avoiding specific questions, the evaluation can simply report that the plaintiff “did not report intrusive flashbacks, nightmares, etc.,” attempting to infer that these symptoms do not exist, thus ruling out PTSD. The following cross-examination was used by this author to combat such an approach:

Q: Doctor, did you ask [plaintiff] if he had been experiencing flashbacks or nightmares of the trauma?
A: As I said, he never reported any; otherwise, I would have put it in my notes.

Q: Doctor, if [the plaintiff] reported these things to you, would that have filled the criteria for finding of PTSD?
A: Yes, but since it was not reported, I had to rule out PTSD according to our guidelines.

Q: Doctor, you did say that you examined the notes of the treating physicians and plaintiff’s expert as part of your preparation for your testimony here?
A: Yes.

Q: Did you not see that, among the many symptoms reported, recurrent nightmares and intrusive flashbacks are being experienced by [the plaintiff]?
A: Yes, I believe I did see reference to that.
Q: Did you not also see that among symptoms noted is an impaired ability to prioritize and problems with short-term memory?
A: Yes, I believe there is some reference to that.

Q: Doctor, in your experience with patients, do you often observe a patient who is trying to get well to try to minimize and forget their problems even when asked about them?
A: Well, sometimes I have seen that.

Q: Doctor, in keeping your experience in mind, did you specifically ask [the plaintiff] whether he experiences intrusive flashbacks or nightmares rather than relying on his memory?
A: Well, no, I thought that the way I asked the questions was sufficient to get an honest answer.

Q: Doctor, if you had asked the specific question as it was identified in the materials you reviewed, rather than relying on his memory, might not that have elicited a positive answer?
A: Perhaps, I cannot say.

The above experience shows that it is imperative to brief the client to go through a checklist approach when discussing problems with the opposing psychiatrist or psychologist. It is one thing to differ on a diagnosis that is very often subjective; it is quite another to conduct the evaluation in a manner that forecloses the gathering of truthful, supporting data. Unfortunately, the latter defensive approach is not uncommon.

A real challenge for the plaintiff is how to present expert testimony of PTSD. It seems that no matter how well the expert is able to communicate with and educate a jury, because the subject is beyond the range of common experience, the presentation of a PTSD case tends to sound too theoretical or clinical. In a recent case involving a helicopter crash, one passenger suffered PTSD, experiencing recurrent and intrusive flashbacks of the event. The expert psychiatrist analogized the symptom to a "broken record that plays over and over again with no control over it." It was quite effective with this particular jury, at least measured by the outcome of the trial. Perhaps a visual analogy would be even more effective, such as "playing a part in a movie over and over again without control over it." Using a mock jury in preparation for the trial can provide some very useful feedback, for there is certainly room for invention in this area.

See Thomas v. McDonnell Douglas Helicopter Co., 67 F.3d 308 (9th Cir. 1995) (tried by this author, the cite deals with liability, not focusing on the emotional damages which the jury found in favor of the passenger).
In this regard, the use of lay witnesses cannot be over-stressed. As one author appropriately stated:

The key to proving psychic trauma lies in the hands of lay witnesses: a neighbor of the plaintiff, a fellow worker, etc., three or four people who knew him prior to injury as a well-functioning, cheerful individual but see him now as a shattered man, suffused with pain and despondency. Their 10-minute descriptions in everyday jurors language of how he was *then* and how he is *today* are worth an entire day’s expert testimony.78

Juries do not always relate to experts, particularly in the mental health field, and tend to be skeptical of things we cannot see. Even a client, a survivor of an aircraft accident and a victim of PTSD, remarked:

Who is going to believe a psychiatrist? Half of them need psychiatrists themselves. What am I going to do, show the jury the burn on my arm? I am ashamed of it. After all, people got killed here. But, nobody can understand what I am going through. How can [the jury]?79

The client was right. Although he received a historically large verdict, in personal observations by this author, it was a stroke of luck. In a post-trial interview with the foreperson of the jury, the foreperson told me how the jury discounted the experts until one of the jurors in deliberation described his wife’s emotional condition resulting from an automobile accident. The foreperson told the other jurors how there was no physical injury, but how it changed his wife’s personality. “This is real,” he told them, and they believed him.80 In fact, a parade of lay witnesses, friends, family members and business colleagues, describing in detail the plaintiff’s actions, accomplishments, disposition, and personality before the accident in comparison with post-traumatic symptomatology, has proven essential to a fully successful case. With this approach, the litigator can create a symbiosis between the experts’, the care givers,’ and the lay witnesses’ testimony—each lending credibility to the other.

Is the DSM-IV criteria impervious to attack? The criteria has provided the field of forensic psychiatry with predictable methodology widely accepted by the mental health profession. It is supported by a series of field trials sponsored by the National

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78 Blinder, supra note 20, at 188.
Institute of Mental Health in collaboration with the National Institute of Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism.\textsuperscript{81} If necessary to establish the efficacy of the use of the DSM-IV by an expert, documentation containing the essential foundation for the development of the criteria is contained in the DSM-IV Sourcebook.\textsuperscript{82} In addition, many papers submitted to the working groups in an effort toward enhanced documentation in the DSM-IV, were published in peer-reviewed journals.\textsuperscript{83}

On the other hand, the DSM-IV proclaims itself to be simply "a helpful guide to clinical practice."\textsuperscript{84} It contains a "Cautionary Statement":

The specified diagnostic criteria for each mental disorder are offered as guidelines for making diagnoses, because it has been demonstrated that the use of such criteria enhances agreement among clinicians and investigators. The proper use of these criteria requires specialized clinical training that provides both a body of knowledge and clinical skills. . . .

. . . The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination' and competency.\textsuperscript{85}

The DSM-IV criteria is largely derived empirically. As one author describes: "Committees of experts arrive at the diagnoses included in the DSM. They reach agreement about a diagnostic category, such as PTSD, and/or the criteria used to define it, by consensus, or when that is not possible, by polling committee members."\textsuperscript{86}

Despite the DSM-IV's wide acceptance, cross-examination questions may still be valid relating to a history of disagreement with the diagnosis of PTSD, the considerable number of changes with the DSM over the years, the voting process by which changes are made, and the fact that even more changes

\textsuperscript{81} See DSM-IV, \textit{supra} note 8, at xix.
\textsuperscript{82} \textsc{American Psychiatric Association Sourcebook for the Diagnostic and Statistical Manual of Mental Disorders} (1994).
\textsuperscript{83} Additional references include: \textsc{Allen Frances et al., DSM-IV Guidebook} (1995), \textsc{DSM-IV Casebook, Ekkehard Othmer & Sieglinde C. Othmer, The Clinical Interview Using DSM-IV} (1994), and \textsc{Michael A. Fauman, Study Guide to DSM-IV} (1994).
\textsuperscript{84} DSM-IV, \textit{supra} note 8, at xv.
\textsuperscript{85} Id. at xxvii.
\textsuperscript{86} See Symes, \textit{supra} note 6, at 195.
are probably underway for future DSM revisions. Could these future changes in retrospect alter a current diagnosis of PTSD? The expert must be prepared for this line of questioning concerning the DSM.\footnote{For a good checklist of cross-examination questions on the reliability and validity of the DSM, see David Faust & Jay Ziskin, Challenging Post-Traumatic Stress Disorder Claims, 38 Def. L. J. 407 (1989); see also Jay Ziskin & David Faust, Coping with Psychiatric and Psychological Testimony (4th ed. 1988).} Practically speaking, however, as a result of decades of effort in categorization and development of a more scientific approach for the mental care provider, the DSM-IV is considered the “bible” and rarely will a treating or forensic psychiatrist testify to the contrary.

Instead, the effective defense often centers around an attack on causation - the causal link between the traumatic event and the plaintiff’s symptoms. Because of the difficulty in refuting whether or not the plaintiff is actually experiencing the claimed nightmares, intrusive thoughts, avoidance, increased arousal, or other PTSD symptoms, the defense may well shift to an attack on causation, questioning whether the symptoms were due to psycho-social stressors rather than the subject event, or caused by pre-existing personality disorders, or other similar factors. Other stressors in the person’s life, unrelated to the alleged traumatic incident, may produce symptoms similar to those of PTSD. Because the defense will be expected to attack causation, the plaintiff must be prepared for a thorough pre-trial examination of his or her personal life in very intimate detail.

The defense must be careful, however, not to create the argument for the plaintiff that the traumatic event exacerbated a pre-existing condition. At the outset of the case, it is important to know the applicable law on the application of the “eggshell” concept in regard to mental or emotional condition.\footnote{See generally Restatement (Second) of Torts § 461 (1964).} It is a widely accepted legal principal that you must take the plaintiff as you find him, regardless of whether the same injury would not have occurred in the so-called normal person.\footnote{See, e.g., Pierce v. Southern Pac. Transp. Co., 825 F.2d 1366, 1372 (9th Cir. 1987) (“The eggshell plaintiff rule simply means that a tortfeasor takes his victim as he finds him.”).} But when it comes to mental or emotional trauma, some jurisdictions may not allow a recovery for the “supersensitive” or predisposed
Defense counsel must be cautious to determine this well before the trial.

A frontal attack on the true PTSD victim on the stand is a gamble that can literally backfire, as in the following example:

A forty year old woman received a serious cut in her calf muscle when an improperly secured floor hatch on a boat gave way, allowing her leg to fall through the flooring while cruising near one of the remote Bahama islands. She was a nurse by profession, so she calmed down everyone on the boat while holding pressure on the deep wound. When she was carried to a doctor ashore, she even assisted in cleansing the wound and explained to the doctor (who was not skilled in surgery) how to run the stitches. After a year of treatment back home, she was still not able to walk well because the accident apparently caused nerve damage, forcing her to forego nursing. Within a month after the injury, she began to experience nightmares, panic attacks when seeing a boat or hearing sounds of engines of all kinds, flashbacks, and fits of temper at the slightest provocation. She was diagnosed with PTSD and began treatment from a psychologist.

In the trial of her case, she presented herself quite well, proudly explaining her efforts on how she was getting her life back together as much as she could. The defendant's insurers, however, maintained throughout the case that her, if not most, PTSD claims were bogus and fashioned their defense strategy on that theme. At first, the defense attempted to attribute her problems to an event many years before the boat accident wherein she successfully fought off a molester. Then, during repetitive cross-examination that kept bringing her back into the boat, defense counsel, in a feeble effort to refresh her recollection of where her feet were placed in the boat as they were underway, showed her a life size blow up of the hatch opening into which her leg fell. Her whole complexion changed as she screamed out in horror as though she were cut all over again. She had to be escorted off the stand by her mother on one side and her attorney on the other. When she resumed the stand an hour later, her answers to the cross-examination were literally

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91 See id.
babble as she was actually shivering with fright. The jury returned a $1.3 million dollar verdict.\textsuperscript{92}

CONCLUSION

It is obvious that claims of PTSD associated with tort actions have increased in number and in kind over the last ten years.\textquotedblright What the future holds for PTSD litigation depends upon the changing rules in various jurisdictions governing recovery for nonphysical harm. It also depends on developments in the diagnostic nomenclature. Mental disorders are regarded with less and less skepticism as knowledge gained through a more scientific approach increases. The care and treatment of these disorders are coming out of the dark ages and gaining wider understanding and acceptance by the public at large. There is no question that the law will follow, making it imperative for all lawyers dealing with personal injury cases to maintain a working knowledge and skill of this important subject.

Comments